



TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH CARE FACILITIES
665 MAINSTREAM DRIVE, SECOND FLOOR
NASHVILLE, TENNESSEE 37243

HOME CARE ORGANIZATION HOME HEALTH BRANCH APPLICATION

This form shall be completed by any agency requesting to establish a home health branch location. Each branch request must be submitted and will require a separate approval. The licensed parent agency must return the branch application request to the above address for review.

NOTE: ANY BRANCH APPROVAL GRANTED IS FOR STATE PURPOSES ONLY. THE DETERMINATION OF WHETHER AN APPLICANT IS A BRANCH LOCATION FOR MEDICARE PURPOSES WILL BE MADE BY CMS.

Agency Name _____

Street Address _____

City/Zip _____ Telephone Number (____) _____

Geographic Area (CON Approved Counties) _____

Current Branch Office Location(s) _____

New Branch Street Address _____

City/Zip _____ Telephone Number (____) _____

Outline the organizational structure (or provide and organizational chart of the:

A. Parent _____

B. Branch _____

Describe how administration, supervision and services will be shared with the parent _____

Services provided at the:	Parent	Branch		Parent	Branch
Skilled Nursing	<input type="checkbox"/>	<input type="checkbox"/>	Home Health Aide Services	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Medical Supplies & Appliances	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Hospice Services	<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Durable Medical Equipment	<input type="checkbox"/>	<input type="checkbox"/>
Medical Social Services	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>
Homemaker Services	<input type="checkbox"/>	<input type="checkbox"/>			

Provide the name and title of the employee(s) responsible for the following: (Please Print)

	Parent	Branch
Contracting for services provided:		
Title:		
Making staff assignments:		
Title:		

Name and title of the employee the branch office will report to _____

Actual mileage from the parent office to the branch _____ Average travel time _____

Average travel time from branch office to patient _____

Parent agency's current caseload _____ Anticipated caseload of branch _____

Comments _____

Signature and title of person completing application request _____

Date of Request _____ Requested Effective Date _____

Please list the counties in which you are providing services:
